



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DISCOVERY HEALTH SERVICES
2248 WELCH STREET
HOUSTON TX 77019

Carrier's Austin Representative Box

#17

Respondent Name

CASTLEPOINT NATIONAL INSURANCE

MFDR Date Received

APRIL 23, 2012

MFDR Tracking Number

M4-12-2728-02 (Previously M4-12-2728-01)

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary Taken from the Request for Reconsideration Letter dated August

18, 2011: "Please review the attached pre-authorizations letters for authorized medical treatment for ...compensable injury. Your company's doctor had a peer-to-peer conference with our physician in which medical treatment was authorized and approved. Please update your records and forward payment..."

Amount in Dispute: \$17,542.20

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Specific to the assertion that services were pre-authorized and that this process should support payment of services rendered, Utilization Review provides an opinion of medical necessity based upon the information submitted by the Provider. UR does not make any determinations on compensability nor does it address whether there are any disputes filed on a claim that would impact payment by the Carrier for services rendered...Further, the Peer Review report pre-dates all submissions for medical necessity by the Provider to Coventry's Utilization Review department. Lastly, the injury employee received a certified copy of the PLN-11 filed on 07/20/2010. Even though the claimant received this information, he took no action to dispute the Carrier's position that ongoing medical treatment was unrelated to the compensable injury sustained on 04/24/2006."

Response Submitted by: Tower Group Companies, 4425 W. Airport Freeway, Ste 230, Irving, TX 75062

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
May 16, 2011	CPT Code 90801	\$285.00	\$248.97
June 7, 2011	CPT Code 96101 x 3 Units	\$390.00	\$0.00
June 8, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 9, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 13, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00

June 14, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 15, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 17, 2011	Physical Performance Test CPT Code 97750	\$433.60	\$404.00
June 20, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 21, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 23, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 27, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 28, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 29, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
June 30, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
July 5, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
July 6, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
July 7, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
July 8, 2011	Physical Performance Test CPT Code 97750	DOS Withdrawn by Requestor	DOS Withdrawn by Requestor
July 25, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
July 26, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
July 27, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
July 28, 2011	Chronic Pain Management Program CPT Code 97799-CP (8 hours @ \$100.00)	\$800.00	\$800.00
TOTAL		\$16,308.60	\$15,852.97

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

On December 13, 2012, the requestor withdrew CPT Code 97750 for disputed date of service July 8, 2011, as this was the only disputed date of service deemed non-compensable per the explanation of benefits.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Tex. Admin. Code §134.600 sets out the fee guidelines for the reimbursement of workers' compensation non-emergency health care requiring preauthorization provided on or after May 2, 2006.
3. 28 Texas Administrative Code §134.204 sets out medical Fee Guidelines for workers' compensation specific services.
4. 28 Texas Administrative Code §134.203 set out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.

5. 28 Texas Administrative Code §133.240 sets out the procedures for medical payments and denials.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated August 26, 2011

- 1 – (50) These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
- 1 – 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. (XA53)

Explanation of benefits dated August 27, 2011

- 1 – (50) These are non-covered services because this is not deemed a ‘medical necessity’ by the payer.
- 1 – 50 – These are non-covered services because this is not deemed a ‘medical necessity’ by the payer. (XA53)

Explanation of benefits dated September 26, 2011

- 1 – (216) Based on the findings of a review organization.
- 1 – 216 – Based on the findings of a review organization. (XB18)

Explanation of benefits dated September 27, 2011

- 1 – (216) Based on the findings of a review organization.
- 1 – 216 – Based on the findings of a review organization. (XB18)

Explanation of benefits dated October 6, 2011

- 1 – (216) Based on the findings of a review organization.
- 1 – 216 – Based on the findings of a review organization. (XB18)

Issues

1. Does an extent of injury issue exist in the dispute?
2. Did the requestor obtain preauthorization approval prior to providing the health care in dispute in accordance with 28 Texas Administrative Code §134.600?
3. Is the respondents denial reason codes ‘50’ and ‘216’ supported?
4. Is the requestor entitled to reimbursement?

Findings

1. The carrier asserts in their response to the DW060 that, “the injured employee received a certified copy of the PLN-11 filed on 07/20/2010.” The PLN-11 filed by carrier dated July 20, 2010 states, “carrier disputed entitlement of future medical appointments and medications for the injuries sustained April 29, 2010 due to peer review which states that there is insufficient clinical documentation that establishes a casual relationship between the April 2006 injury and the patient current complaints.” The PLN-11 on file is not valid for an issue of extent of injury. Therefore, an extent of injury issue does not exist in this case.
2. 28 Texas Administrative Code, Section §133.240(b) states, “For health care provided to injured employees not subject to a workers’ compensation health care network established under Insurance code Chapter 1305, the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under Chapter 134 of the title (relating to Benefits—Guidelines for Medical Services, Charges, and Payments.” 28 Texas Administrative Code, Section §134.600(c)(1)(B) states, “The carrier is liable for all reasonable and necessary medical costs relating to the health care...only when the following situations occur...preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care.” 28 Texas Administrative Code §134.600(p)(7) requires preauthorization of “all psychological testing and psychotherapy, repeat interviews, and biofeedback, except when any service is part of a preauthorized or division exempted return-to-work rehabilitation program.” Review of the submitted preauthorization letter dated April 28, 2011 supports that Psychological Testing x 3 hours, CPT Code 96101) and Intake, 1 hour, CPT Code 90801 was approved under authorization number 9110024 with a start date of April 26, 2011 and an end date of June 26, 2011 which includes the disputed dates of service.
28 Texas Administrative Code §134.600(p)(10) requires preauthorization of “chronic pain management program/interdisciplinary pain rehabilitation.” Review of the submitted preauthorization letter dated May 26, 2011 supports the Chronic Pain Management Program was approved for 10 Visits, 5 x Week x 2 Weeks under authorization number 9123783 with a start date of May 24, 2011 and an end date of

July 24, 2011 which includes the disputed dates of service. Review of the submitted preauthorization letter dated June 24, 2011 supports the Chronic Pain Management Program was approved for an additional 10 day (80 hours) under authorization number 9137808 with a start date of June 23, 2011 and an end date of August 5, 2011 which includes the disputed dates of service.

3. Review of the submitted documentation finds the respondent's explanation of benefits denied the disputed services based on "50 – These are non-covered services because this is not deemed a 'medical necessity' by the payer" and "216 – Based on the findings of a review organization." 28 Texas Administrative Code §133.240(b) states in pertinent part that "...the insurance carrier shall not deny reimbursement based on medical necessity for health care preauthorized or voluntarily certified under chapter 134..." Review of the submitted documentation finds that the requestor did submit documentation to sufficiently support that preauthorization was obtained by the carrier prior to rendering the services in dispute. For this reason, the division finds that claim adjustment reason codes "50" and "216" are not supported. Therefore the disputed services will be reviewed per applicable division rules and fee guidelines.
4. Per 28 Texas Administrative Code, Section §134.203 (c)(1) the calculations for CPT Codes 90801, 96101 and 97750 are as follows:
CPT Code 90801: \$54.54 WC CF/33.9764 Medicare CF x \$155.10 participating amount = \$248.97. The total MAR for CPT Code 90801 billed on May 16, 2011 is \$248.97. This amount is recommended for reimbursement.
CPT Code 96101: Per the requestor's *Table of Disputed Services*, CPT Code 96101 was billed on June 7, 2011. Review of the documentation submitted finds no bills or EOBs listing CPT Code 96101 for date of service June 7, 2011. Therefore, reimbursement cannot be recommend.
CPT Code 97750: \$54.54 WC CF/33.9764 Medicare CF x \$31.46 participating amount x 8 units = \$404.00. The total MAR for CPT Code 97750 billed on June 17, 2011 is \$404.00. This amount is recommended for reimbursement.

Per 28 Texas Administrative Code, Section §134.204(h)(5)(B), a chronic pain management program shall be reimbursed \$125.00 per hour for a CARF accredited program. Units of less than one hour shall be prorated in 15 minute increments. A single 15 minute increment may be billed and reimbursed if greater than or equal to eight minutes and less than 23 minutes. A CARF accredited program is indicated by using the modifier –CA. The requestor did not provide the CARF accredited modifier; therefore, the monetary value of the program will be 80% of the CARF accredited value. CPT code 97799-CP will be reimbursed in accordance with 28 Texas Administrative Code, Section §134.204(h)(5)(B) at \$100.00 per hour as follows per requestor's *Table of Disputed Services*:

DOS June 8, 2011: \$100.00 x 8 hours = \$800.00
DOS June 9, 2011: \$100.00 x 8 hours = \$800.00
DOS June 13, 2011: \$100.00 x 8 hours = \$800.00
DOS June 14, 2011: \$100.00 x 8 hours = \$800.00
DOS June 15, 2011: \$100.00 x 8 hours = \$800.00
DOS June 20, 2011: \$100.00 x 8 hours = \$800.00
DOS June 21, 2011: \$100.00 x 8 hours = \$800.00
DOS June 23, 2011: \$100.00 x 8 hours = \$800.00
DOS June 27, 2011: \$100.00 x 8 hours = \$800.00
DOS June 28, 2011: \$100.00 x 8 hours = \$800.00
DOS June 29, 2011: \$100.00 x 8 hours = \$800.00
DOS June 30, 2011: \$100.00 x 8 hours = \$800.00
DOS July 5, 2011: \$100.00 x 8 hours = \$800.00
DOS July 6, 2011: \$100.00 x 8 hours = \$800.00
DOS July 7, 2011: \$100.00 x 8 hours = \$800.00
DOS July 25, 2011: \$100.00 x 8 hours = \$800.00
DOS July 26, 2011: \$100.00 x 8 hours = \$800.00
DOS July 27, 2011: \$100.00 x 8 hours = \$800.00
DOS July 28, 2011: \$100.00 x 8 hours = \$800.00

The total maximum allowable reimbursement (MAR) for CPT Code 97799-CP is \$15,200.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is \$ 15,852.97.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$15,852.97 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____ Signature	_____ Medical Fee Dispute Resolution Officer	_____ February 1, 2013 Date
_____ Signature	_____ Medical Fee Dispute Resolution Manager	_____ February 1, 2013 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision* together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party.****

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.